CARES

APPLICATION

COMPREHENSIVE ADOLESCENT REHABILITATION AND EDUCATION SERVICE
MOUNT SINAI ST. LUKE'S HOSPITAL
411 WEST 114TH STREET, 2ND FLOOR
NEW YORK, NY 10025
PHONE: (212) 523-3083
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CARES

The Comprehensive Adolescent Rehabilitation and Education Service at Mount Sinai St. Luke's, offers a wide range of services to address issues interfering with optimal functioning for teens and young adults. We provide a full range of targeted and integrated mental health and substance abuse services. Our accomplished clinicians have expertise in the unique developmental needs of adolescents and young adults. Youth interested in CARES will first engage in a comprehensive evaluation. Based on one's motivation and readiness to make changes in their lives, the most appropriate Level of CARES (PRECARES, CARES Academy, AFTERCARES) will be recommended, and an individualized treatment program will be designed.

PRECARES

WHY:

Adolescents face various struggles on a day to day basis that manifest in emotional and behavioral difficulties. Often times, Adolescents may not know how and where to ask for help.

WHO:

Adolescents who may not believe they have a problem, even though others in their lives are telling them so; Alternatively, Adolescents who may be starting to acknowledge concerns about problems, and might consider changing, but are wavering or uncertain.

WHAT:

PreCARES provides an open, respectful, and safe environment where Adolescents can meet supportive staff and engage in discussion about their struggles. Through a combination of therapeutic services, Adolescents may increase motivation, raise awareness about themselves, and learn to explore the pros and cons of making change in their lives.

HOW:

PreCARES offers a combination of individual, group, family, and/or psychopharmacological therapies that are designed to empower teens to make decisions based on what is best for themselves. These services are based on evidenced-based practices of Motivation Enhancement Techniques (MET) and Dialectical Behavior Therapy (DBT).

WHEN:

1 – 4 sessions per week, for 3 – 6 months

CARES Academy

WHY:

An Adolescent's functioning can be limited by emotional and behavioral difficulties, including emotional distress, impulsivity, drug and alcohol use, and missing school. *CARES Academy is for those teens who need both treatment and school in a combined setting.*

WHO:

Adolescents seeking recovery from interpersonal, emotional, behavioral, substance related, and academic problems; Adolescents who acknowledge concerns about their problems, are considering change, or are committed and planning to make changes in the immediate future.

WHAT:

CARES Academy is a safe and therapeutic school for NYC public high school students. It combines a distinct educational environment with intensive psychiatric treatment, and is designed for those teens who require a significant level of structure and skill building to turn their lives around, but who live in their community.

HOW:

CARES Academy provides multidisciplinary, daily therapeutic services including individual (2x/wk), group (5x/wk), milieu (daily), family (1x/wk), and pharmacological treatments. Treatment framework is based on the principles of Dialectical Behavior Therapy, and also integrates MET, CBT, Psychodynamic, and Family Systems approaches.

WHEN:

5 days per week, 9a – 3:30p, for 6 – 12 months

AFTERCARES

WHY:

The transition from adolescence to adulthood can be complicated by emotional, behavioral, and family issues. Being a Young Adult requires balancing responsibilities of self, family, career, and community.

WHO:

Adolescents and Young Adults who are actively taking steps to make changes in their lives, or who have achieved their initial goals and are now are working to maintain their gains.

WHAT:

AfterCARES provides an open, respectful, and safe environment where Young Adults can develop the skills they need to live a balanced and fulfilling life. Becoming a member of AfterCARES provides access to a range of services, dedicated clinicians, and a network of peers. Young Adults will make strides toward achieving maturity and independence, effectively managing emotions, sustaining healthy relationships, developing a clear sense of self, identifying life goals, and adopting healthy behaviors.

HOW:

AfterCARES offers a combination of individual, group, family, and psychopharmacological therapies, as well as peer support and mentoring. These services are based on Motivation Enhancement Techniques and Supportive Psychotherapy.

WHEN:

1 – 3 sessions per week, for 3 – 6 months

411 West 114th Street, 2nd floor, NY, NY 10025
T: 212.523.7233 (information)
T: 212.523.3083 (referrals)
F: 212.523.7547
W: www.childfamilyinstituteny.org

PLEASE NOTE: ***both "Applicant Form" and "Referral Form" must be completed in full in order to be reviewed.***

CARES

APPLICATION: APPLICANT FORM

Dear Applicant,
You are applying for a position in CARES, an alternative high school program that combines regular school classes with instruction groups that teach skills to help manage personal relationships and feelings. We are very interested in hearing about you and why you would like to participate in our program. Please answer the questions below as completely as you can. You may use the back of the form for additional writing space, if needed. We look forward to meeting with you!

APPLICANT NAME: _____DATE OF BIRTH:____/____/____ TODAY'S DATE:____/____/____

1. WHAT NAME DO YOU PREFER TO BE CALLED? _____

2. HOW DID YOU HEAR ABOUT CARES? _____

3. PLEASE WRITE ONE OR TWO PARAGRAPHS TELLING US WHY YOU WANT TO BE IN CARES.

_____

_____

_____

4. PLEASE TELL US SOMETHING ABOUT YOUR INTERESTS AND YOUR PLANS FOR LIFE AFTER HIGH SCHOOL.

_____

_____

_____

5. LIST THE THREE BIGGEST PROBLEMS THAT HAVE MADE IT HARD FOR YOU TO ATTEND HIGH SCHOOL:

PROBLEM #1: _____

PROBLEM #2: _____

PROBLEM #3: _____

6. HOW DO YOU PLAN TO OVERCOME THESE PROBLEMS SO THAT YOU CAN ATTEND PROGRAM EVERY DAY?

PROBLEM #1: _____

PROBLEM #2: _____

PROBLEM #3: _____

7. ARE THERE ANY ADULTS (FAMILY OR FRIENDS) IN YOUR LIFE NOW WHOM YOU CAN TRUST WHEN YOU NEED HELP? IF YES, WHO ARE THEY?

_____

8. HOW MANY DAYS OF TREATMENT PER WEEK DO YOU THINK YOU NEED IN ORDER TO MEET YOU GOALS? (CIRCLE ONE): **1 2 3 4 5**

9. CARES APPLICANTS ARE EXPECTED TO ATTEND CLASSES AND TREATMENT GROUPS AT SCHOOL *5 DAYS PER WEEK*, AND TO PARTICIPATE IN WEEKLY INDIVIDUAL SESSIONS AND FAMILY MEETINGS. DO YOU AGREE TO FULFILL THIS EXPECTATION?
(*CIRCLE ONE*): **YES, I AGREE** OR **NO, I DON'T AGREE**

STUDENT SIGNATURE: _____ DATE: _____

CARES

APPLICATION: REFERRAL FORM

Please note that all items must be completed for this form to be reviewed.

1. APPLICANT INFORMATION

NAME: _____ DATE OF BIRTH: _____/_____/_____ GENDER:_____

ADDRESS: _____

PHONE #: _____

2. PARENT OR LEGAL GUARDIAN

NAME: _____ RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

PHONE #: _____

3. WHY DO YOU THINK THIS APPLICANT AND HIS OR HER FAMILY IS APPROPRIATE FOR CARES?

_____

_____

_____

_____

4. WHAT HAS PREVENTED THE APPLICANT FROM SUCCESSFULLY ATTENDING SCHOOL/WORK?

_____

_____

_____

_____

5. WHAT OBSTACLES MIGHT HINDER THIS APPLICANT AND FAMILY'S ABILITY TO PARTICIPATE IN TREATMENT?

_____

_____

_____

6. HOW MIGHT THESE OBSTACLES BE OVERCOME?

_____

_____

_____

PSYCHIATRIC INFORMATION

7. CURRENT PSYCHOTHERAPIST

NAME: _____

ADDRESS: _____

PHONE # _____

8. PSYCHIATRIST OR MEDICATION PRESCRIBER, IF ANY

NAME: _____

ADDRESS: _____

PHONE # _____

9. CURRENT MEDICATIONS, IF ANY (NAME, DOSAGE, FREQUENCY)

A. _____

B. _____

C. _____

10. DO YOU CURRENTLY HAVE ANY CASE MANAGEMENT SERVICES (ICM, SCM, BCM, WAIVER, HEALTH HOME, PREVENTIVE, ETC.)?

IF SO, PROVIDE CONTACT INFO:

NAME (AGENCY & WORKER): _____

ADDRESS: _____

PHONE # _____

TYPE OF SERVICE: _____

11. DESCRIBE THE EMOTIONAL AND BEHAVIORAL PROBLEMS OF THIS APPLICANT, INCLUDING A HISTORY OF PAST TREATMENTS AND DIAGNOSES.

_____

_____

_____

_____

12. DOES THE APPLICANT CURRENTLY USE OR HAVE A HISTORY OF ALCOHOL AND/OR DRUG USE? IF SO, PLEASE SPECIFY.

_____

_____

_____

_____

13. DOES THE APPLICANT HAVE A HISTORY OF PSYCHIATRIC HOSPITALIZATION OR INPATIENT REHABILITATION? IF SO, PLEASE SPECIFY.

_____

_____

_____

_____

14. HAS APPLICANT EVER HAD NEUROPSYCHOLOGICAL TESTING/ASSESSMENT? **Y/N** IF SO, PLEASE ATTACH.

MEDICAL INFORMATION

14. PRIMARY CARE PROVIDER

NAME: _____

ADDRESS: _____

PHONE # _____

15. DESCRIBE THE APPLICANT'S MEDICAL PROBLEMS, IF ANY, INCLUDING ANY MEDICATIONS TAKEN.

_____

_____

_____

16. THE APPLICANT'S LAST PHYSICAL EXAM WAS ON: _____/_____/_____ (MM/DD/YY)

ACADEMIC INFORMATION

17. MOST RECENT SCHOOL

NAME: _____

ADDRESS: _____

PHONE # _____

18A. HIGHEST GRADE COMPLETED: _____ 18B. HIGH SCHOOL CREDITS EARNED: _____.

19. DOES THE APPLICANT HAVE A HISTORY OF ACADEMIC DIFFICULTIES, INCLUDING LEARNING DISORDERS? IF SO, PLEASE SPECIFY.

_____

_____

_____

20. DOES THE APPLICANT HAVE AN INDIVIDUALIZED EDUCATION PLAN (I.E.P.) THROUGH THE DEPARTMENT OF EDUCATION? _____YES

_____NO

*IF YES, PLEASE ATTACH.

21. DAYS OF WORK/SCHOOL MISSED IN PAST 6 MONTHS (ESTIMATE # OR %) : _____

PLEASE INDICATE PRIMARY REASONS FOR MISSING SCHOOL/WORK:

_____

_____

_____

22. INSURANCE INFORMATION (PLEASE CHECK ALL THAT APPLY)

MEDICAID? _____YES _____NO MEDICAID # _____

MEDICAID MANAGED CARE? _____YES _____NO COMPANY _____

OTHER INSURANCE _____YES _____NO

IF YES, WHAT TYPE?_____ GROUP # _____

NAME OF PERSON INSURED:_____ SS # OF PERSON INSURED:_____-_____-_____

REFERRAL AGREEMENT: PLEASE READ AND THEN SIGN BELOW

I, the undersigned, am referring the applicant described above for consideration by CARES. I understand that this referral must be screened by the CARES Clinical Team prior to any further application procedures, and that both an intake with student and guardian and educational testing must occur before an admission decision is made.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ PHONE #: _____

TITLE/RELATION TO APPLICANT: _____

HOW DID YOU HEAR ABOUT CARES?

_____

_____

DOCUMENTATION REQUIRED WITH REFERRAL APPLICATION

The following documents will need to be submitted with the Referral Application:

- ☐ APPLICANT'S SCHOOL TRANSCRIPTS (not needed if student is incoming 9th grader)
  (Report Cards may occasionally be substituted if transcripts prove difficult to obtain)
- ☐ COPY OF APPLICANT'S INDIVIDUALIZED EDUCATION PLAN (I.E.P.) if applicable

DOCUMENTATION REQUIRED AT INTAKE APPOINTMENT

The following documents will need to be brought to the intake appointment in order for an applicant to be fully enrolled in CARES. These documents may be submitted with this application, or brought by the applicant and parent/guardian to the intake evaluation:

- ☐ COPY OF PARENT'S PHOTO IDENTIFICATION
  (or copy of APPLICANT'S PHOTO IDENTIFICATION if 18 or older)
- ☐ COPY OF APPLICANT'S BIRTH CERTIFICATE
- ☐ COPY OF APPLICANT'S SOCIAL SECURITY CARD
- ☐ APPLICANT'S IMMUNIZATION RECORD
- ☐ WRITTEN RECORD OF APPLICANT'S PHYSICAL EXAM WITHIN PAST 6 MONTHS;
  OR
  PROOF OF APPOINTMENT MADE TO OBTAIN PHYSICAL EXAM